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Supreme Court, U.S.
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No. 94-2018

In The

Supreme Court of the United States

October Term, 1995

LINDA J. GREGORY,

Petitioner,

v.

THOMAS L. JACOBS & ASSOCIATES AND ATLANTIC RICHFIELD COMPANY,

Respondents.

On Petition For Writ Of Certiorari
To The United States Court Of Appeals
For The Fifth Circuit

BRIEF IN OPPOSITION TO PETITION FOR WRIT OF CERTIORARI

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RESPONDENTS' STATEMENT OF QUESTIONS PRESENTED

1. Should this Court review the question, conceded by petitioner in the court of appeals, whether ERISA plan language giving the administrator the "authority to make determinations regarding benefit entitlement" under the "health and capacity to work criteria defined in the plan," and providing that its "decision" on the review of a denied claim shall be "final," vests it with discretionary authority so that its decisions on benefit eligibility are reviewed under an "arbitrary and capricious" standard?

2. Should this Court review the question, not presented by this case, whether in cases where the ERISA plan language grants no discretionary authority, the administrator's factual determinations are governed by the "arbitrary and capricious" review standard?

3. Should this Court review the question, not presented by this case, whether any, or a scintilla of evidence, as opposed to substantial evidence, is sufficient under ERISA to uphold the administrator's decision to deny benefits under the "arbitrary and capricious" review standard?*

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* Respondent Thomas L. Jacobs & Associates was merged into UNUM Life Insurance Company and was dissolved as of January 1, 1994. UNUM Life Insurance Company is a wholly owned subsidiary of UNUM Corporation. Respondent Atlantic Richfield Company's affiliates and subsidiaries (other than wholly owned subsidiaries) are ARCO Chemical Company, Lyondell Petrochemical Company and Vastar Resources, Inc.

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On Petition For Writ Of Certiorari To The United States Court Of Appeals For The Fifth Circuit

BRIEF IN OPPOSITION TO PETITION FOR WRIT OF CERTIORARI

Respondents, Thomas L. Jacobs & Associates ("Jacobs") and Atlantic Richfield Company ("ARCO"), respectfully request that this Court deny the Petition for Writ of Certiorari seeking review of the Fifth Circuit's decision in this case. That decision is a *per curiam* unreported decision without any precedential effect.

I

RESPONDENTS' STATEMENT OF THE CASE

For purposes of this brief in opposition, respondents rely on the District Court's Findings of Fact (Appendix B

to Petition, pp. 33-44), the Fifth Circuit's conclusion that "we are . . . faced with the undeniable fact that the record reflects substantial evidence supporting [Jacob's] decision" (Appendix D to Petition, p. 53), and the following statement of the case which adds several facts selectively edited from the Petition and demonstrates that this case was decided based on the unique language of one employee benefit plan and one person's particular medical history and physical capabilities.

A. Proceedings Below

In 1990, petitioner Linda J. Gregory ("Ms. Gregory") filed suit against Jacobs and ARCO under the Employee Retirement Income Security Act of 1974 ("ERISA"), as amended, 29 U.S.C. §§ 1001, *et seq.*, to recover benefits under a self-funded long-term disability benefit plan (the "Plan") established by ARCO. She had sustained a work injury in 1983.

Aetna Life Insurance Company ("Aetna") originally administered claims under the Plan. In 1984, Aetna determined that Ms. Gregory was totally disabled from her own occupation as a lease pumper, and she was paid disability benefits.

The Plan's definition of "Totally Disabled," applicable after the first two years of benefit payments, requires that the participant, "because of a continuing *medically determinable* physical or mental impairment resulting from illness or injury," be "unable to engage in any gainful employment or occupation for which [the participant is] reasonably qualified by education, training or experience. . . . " (Emphasis added).

By a 1987 Administration Agreement, Jacobs became Claims Administrator for the Plan. Jacob's Benefit Review Committee serves as the ERISA claims review fiduciary, conducting the appeal procedure for denied claims required by ERISA in 29 U.S.C. § 1133. In 1988, following a review of Ms. Gregory's claim file and an independent medical examination report by Dr. Lawrence Wilk, Jacobs determined that she no longer fit the Plan's definition of "total disability" with respect to "any occupation," and notified her that benefits would be terminated in January, 1989. At this time, Ms. Gregory was only 34 years old – over three decades away from "normal retirement age."

Ms. Gregory retained counsel and filed an administrative appeal of the benefit denial. Her basic argument was that she had a small herniation of disc in the lumbar spine and complaints of pain. The Jacobs Benefit Review Committee, serving as ERISA claims review fiduciary, affirmed the benefit termination in 1989.

In reviewing the Benefit Review Committee's decision, the District Court concluded that the Plan "specifically gave [Jacobs] discretionary authority to make determinations regarding eligibility for benefits and discretionary authority to review denied claims." Applying the "arbitrary and capricious" standard of review, it concluded that there was little, if any, objective medical evidence of Ms. Gregory's continued disability in 1988, and that the Review Committee did not act "arbitrarily or capriciously" when it decided that her disability benefits had been properly terminated. (Appendix B to Petition, pp. 44-7).

In her brief on appeal, Ms. Gregory argued to the Fifth Circuit that the District Court erred because (1) it applied an "arbitrary and capricious" rather than a *de novo* standard of review; (2) the Benefit Review Committee did not personally review certain MRI film; (3) benefits were terminated notwithstanding a note by Dr. E. Richard Blonsky, Jacobs' Medical Director, that she needed a mild work hardening program and probably a pain management program; (4) the "treating physician" rule used in social security cases should be incorporated into ERISA; and (5) the Review Committee's decision was made subject to a later determination by Jacobs' rehabilitation manager that she was able to perform specific occupations available in Texas in view of her skills and restrictions.

At oral argument before the Fifth Circuit, Ms. Gregory's counsel immediately conceded that the "arbitrary and capricious" review standard applied, and argued only that the Benefit Review Committee's decision was an abuse of discretion.

B. Statement of Facts

Ms. Gregory was born on January 1, 1954. She had an 11th grade education and a General Equivalency Diploma. Before working for ARCO, she had been employed as both a restaurant and bar waitress.

In 1985, two years after her injury, Ms. Gregory had a laminectomy. In 1985-86, she was in a work hardening program and was able to lift regularly up to 60 pounds. In 1988, she raised cows as a hobby, feeding the cows and

selling the calves, and she was able to do light housework, cook and drive an automobile without restriction while visiting her parents, family and friends. Able to walk without assistance, she never asked for or used a cane or any walking device. She never went to the Texas Employment Commission to seek a job referral.

In 1985 and 1986, Dr. Mohammed Khalil, Ms. Gregory's treating physician, submitted reports to Aetna in which he listed her "physical impairment" in accordance with the Federal Dictionary of Occupational Titles as a class 4 impairment, meaning she had a moderate limitation of functional capacity and was capable of "clerical, administrative sedentary activities." In 1988, Dr. Khalil referred Ms. Gregory to a work hardening program at the South Texas Work Assessment and Rehabilitation Center. It reported that her maximum lifting range was 65 pounds, that she had pushing and pulling capabilities in the 142 pound range, and that her carrying range was 45 pounds for a distance of 30 feet. It also reported that her observed standing and sitting tolerances were 41 and 36 minutes. All of this information was in her claim file maintained originally by Aetna and later by Jacobs.

In the 1987 Administration Agreement, Jacobs agreed to review initial claims to determine whether or not the claimant has "qualified for Benefits by reason of the health and capacity to work criteria defined in the Plan." It also agreed to review periodically the status of *all* disability claims and to determine if each claimant continues to meet the Plan's definition of total disability. The Administration Agreement provides:

> [ARCO] has appointed Jacobs claims administrator with authority to make determinations regarding Benefit entitlement under the Plan, including review of denied claims. Jacobs agrees to be named fiduciary, as defined in ERISA, for the purpose of claim determination and review of denied claims. Jacobs' decision on any claim shall be final.[1]

During 1988, as part of a routine review of all claims of ARCO participants, Jacobs reviewed Ms. Gregory's claim file and requested information and all the medical records from her and Dr. Khalil. In his response, Dr. Khalil concluded that she had a small disc herniation based on a MRI, and that she complained of lower back pain. He also offered his opinion that she could not even engage in sedentary work. His report, however, was not specific in indicating the degree of her medical problems and how they restricted her movement activities. Furthermore, the MRI relied on by Dr. Khalil, which he did not submit to Jacobs, was performed without contrast enhancement. This is a simple procedure involving injection of harmless dye to differentiate between scar tissue and herniated disc material. Hence, the physician could not conclude that the images seen on the MRI film were herniated disc material as opposed to well-healed scar tissue from the 1985 laminectomy.[2]

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[1] As pointed out to the District Court, Jacobs has a financial incentive to approve, rather than deny, long-term disability claims in that its compensation is based on the number of *active* claims administered. (Transcribed Proceedings before District Court, p. 209).

[2] Transcribed Proceedings before District Court, pp. 240-1; Appellees' Record Excerpts, Tab 3, pp. 60-4.

Jacobs concluded that an independent medical examination was appropriate. Dr. Khalil's 1988 response was not specific in indicating the severity of her medical condition or how it restricted her ability to move. Furthermore, the response sharply conflicted with his 1985 and 1986 reports to Aetna which stated that she was capable of "clerical, administrative sedentary activities," with her substantial lifting ability shown in the 1985-86 work hardening program, with her ability to walk without assistance and conduct her daily activities, and with the detailed objective findings in 1988 of her physical capabilities in the work assessment and rehabilitation report.

Pursuant to the Plan's provisions, Jacobs arranged for an independent medical examination by Dr. Lawrence Wilk, a board certified orthopedic surgeon whose experience included treatment of herniated discs and performing laminectomies. In his report, Dr. Wilk stated that after review of X-rays, MRI film and bone scans, he found "some minor degenerative changes, but nothing that I would say is significantly abnormal." The test results were within normal limits. In response to the question of "What objective medical findings are noted which substantiate continued total disability at this point," he wrote that the "only" objective finding was a well-healed laminectomy scar from 1985. He added that "all other information" supporting total disability was "purely subjective." As indicated above, the Plan requires proof of a continuing "medically determinable" impairment. While noting that Ms. Gregory complained of lower back pain, he found that she nevertheless had full range of motion which included bending forward; no muscle

spasm, no areas of tenderness, and no areas of inflammation; and normal reflexes, neurological findings and gait pattern. He determined that she was totally disabled from performing her "own occupation" as a lease pumper, and that she should refrain from bending, stooping, squatting or lifting objects over 15-20 pounds. Contrary to the Petition's assertion, he did in fact respond to the question of whether she was "capable of any occupation for which she is qualified based on age, training, education and experience." In response to this question, his report stated that she was capable of "limited sedentary activities" and added that she was a good candidate for vocational rehabilitation because she was an "intelligent, motivated young lady."[3] As shown above, the term "activities" also is used in the description of a class 4 impairment (the very designation used by Dr. Khalil) when the individual is capable of "clerical, administrative sedentary activities".

Following receipt of Dr. Wilk's report, Jacobs had Dr. Blonsky review Ms. Gregory's claim. Dr. Blonsky, who is board certified in neurology and pain management, indicated in his review notes that she would need a mild work hardening program and probably a pain management program,[4] and stated that she could never return to

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[3] Appellant's Record Excerpts, Tab 8, p. 80239.

[4] As stated above, Ms. Gregory had enrolled in a work hardening program in 1985-6 and displayed substantial lifting capabilities. The claim file showed that the report detailing Ms. Gregory had been in a work hardening program was received *after* Dr. Blonsky had suggested a work hardening program. Neither ERISA nor the Plan requires Jacobs to offer an additional work hardening program or a pain management program, which matters are the obligation of the claimant.

her prior job. He concluded, however, that she "surely could do lighter work" and found no reason "why she would be restricted only to sedentary work."

Based on all of the information contained in Ms. Gregory's claim file, Jacobs determined that Ms. Gregory no longer met the Plan's definition of total disability. Her injury was in 1983. She did not have a herniated disc, and her complaints were purely subjective. The only objective medical evidence regarding total disability was merely a well-healed 1985 laminectomy scar.

Retaining an attorney, Ms. Gregory appealed Jacobs' determination that she was no longer entitled to benefits, and she was represented by counsel during the administrative appeal, the District Court litigation and the Fifth Circuit appeal.

During the appeal, Dr. Khalil furnished Jacobs with three medical reports but did not submit the raw data – the MRI film – on which the clinical impression of a small disc herniation was based. In particular, he admitted at trial that he did not know whether the radiologist who performed the MRI had the benefit of a surgical report indicating a 1985 laminectomy in the lumbar region, or if the radiologist could differentiate between well-healed scar tissue from the laminectomy and herniated disc material unless he had done a contrast enhancement. At trial, the District Court received testimony by Dr. Blonsky which showed that the MRI film relied on by Dr. Khalil did *not* have contrast enhancement, and thus would not allow the viewer to differentiate between scar tissue arising from the 1985 laminectomy and a possible disc herniation. Dr. Khalil further admitted that a herniated disc did not necessarily make an individual totally disabled,

and that in any event he was not a vocational rehabilitation specialist.

In 1988, Dr. Christopher Chaput, Ms. Gregory's neurosurgeon, submitted a report stating his impression that she had a herniated disc as confirmed by a recent myelogram. He submitted no objective medical data, however, including any test data. He also offered his opinion that she was unable at that time to perform even sedentary work but admitted, at trial, that a herniated disc does not necessarily render a person totally disabled and that he was not a vocational rehabilitation expert. Although Dr. Chaput wrote that she had a 30 minute restriction on sitting and a 15 minute restriction on standing, he admitted that he did not recall if he had actually observed her sitting or standing for those periods. Dr. Chaput's report was based on Ms. Gregory's oral statements and conflicted with the 1988 work assessment and rehabilitation report that she had observed sitting and standing tolerances of 36 and 41 minutes. Dr. Chaput further admitted that contrast enhancement for a MRI would be helpful in differentiating between scar tissue and herniated disc material.

Ms. Gregory did not submit the opinion of a vocational expert that she was totally disabled from any occupation for which she was reasonably qualified by education, training or experience.

In 1989 the Benefit Review Committee concluded that Ms. Gregory, in view of her youth and all of the objective evidence considered as a whole, was not totally disabled as defined in the Plan assuming that a sedentary occupation fitting her restrictions was available in Texas. Jacobs' rehabilitation manager participated in the meeting. The

Review Committee directed him to identify sedentary occupations in Texas appropriate for her. The Review Committee notes reflect that if he were unable to identify any such occupation, the claim associate responsible for her file was to return the claim for further proceedings which would have resulted in the reinstatement of benefits. The rehabilitation manager's report demonstrated that there were numerous occupations in Texas for which she was reasonably qualified by age, education, training and experience and in light of her physical limitations. He identified a number of occupations he deemed appropriate for her including: waitress (a position she had previously held), a hostess, a miller of chemicals, a children's attendant, a coat-checker, a counter clerk, and a household companion.

C. District Court and Fifth Circuit Decisions

The District Court held that the "Administration Agreement specifically gave [the Benefit Review Committee] discretionary authority to make determinations regarding eligibility for benefits and discretionary authority to review denied claims," and that the "arbitrary and capricious" standard of review therefore governed its determination. Following a two-day bench trial, it concluded that "little, if any, objective medical evidence" supported the total disability claim, and that the claim file contained "sufficient evidence" on which the Review Committee could base its determination that Ms. Gregory no longer met the Plan's standard for total disability. Consequently, it found that the Review Committee did not act "arbitrarily and capriciously" in upholding the denial of benefits. (Appendix B to Petition, pp. 44-7).

At the outset of oral argument before the Fifth Circuit, Ms. Gregory's counsel conceded that the "arbitrary and capricious" review standard applied, a concession noted by Jacobs and ARCO in their Opposition to Appellant's Motion for Extension of Time to File a Petition for Panel Rehearing. (Opposition, page 1). He then argued only that the Benefit Review Committee had abused its discretion.

The Fifth Circuit affirmed in a brief, *per curiam* decision without "precedential value," noting that the opinion should not be published because it was decided "on the basis of well-settled principles of law." (Appendix D to Petition, p. 51). It concluded, based on *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989), that the District Court applied the proper standard – abuse of discretion – in reviewing the Benefit Review Committee's decision.[5] In affirming, the appellate court stated that "we are . . . faced with the undeniable fact that the record reflects *substantial* evidence supporting [Jacobs'] decision." (Emphasis added). It added: "We therefore cannot conclude that the administrator's decision was arbitrary." (*Id.* at 52-3).

II

SUMMARY OF ARGUMENT

This Court should reject the Petition for Writ of Certiorari which is premised on a non-existent conflict

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[5] Significantly, the appellate court cited *Firestone*, not *Pierre v. Connecticut General Life Ins. Co.*, 932 F.2d 1552 (5th Cir. 1991), *cert. denied*, 502 U.S. 973 (1991).

among the Circuits over an issue that Ms. Gregory conceded before the Fifth Circuit.

No split exists among the Circuits as to what ERISA plan language is necessary to give a claims review fiduciary the discretionary authority to determine benefit eligibility. The Administration Agreement vests Jacobs with the authority to *"determine"* whether the claimant has *"qualified for benefits by reason of the health and capacity to work criteria defined in the Plan,"* gives it the "authority to make *determinations* regarding benefit entitlement under the Plan," including the review of denied claims as "named fiduciary [under] ERISA," and specifies that its "decision on any claim shall be *final.*" (Emphasis added). The Circuits are in agreement that this broad power-granting language to determine benefit eligibility is sufficient to invoke a deferential review under *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989).[6] Moreover, Ms. Gregory's counsel conceded the standard of review at the outset of oral argument before the Fifth Circuit.

The second question presented is not even raised by the Fifth Circuit's decision. Ms. Gregory seeks to challenge *Pierre v. Connecticut General Life Ins. Co.*, 932 F.2d

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[6] *Bogue v. Ampex Corp.*, 976 F.2d 1319 (9th Cir. 1992), *cert. denied*, 113 S.Ct. 1847 (1993); *Eley v. Boeing Co.*, 945 F.2d 276, 278 (9th Cir. 1991); *Boyd v. Trustees of United Mine Workers Health & Retirement Funds*, 873 F.2d 57, 59 (4th Cir. 1989); *Richards v. United Mine Workers of America Health & Retirement Plan*, 895 F.2d 133, 135 (4th Cir. 1990); *Davis v. Kentucky Fin. Co. Retirement Plan*, 887 F.2d 689, 694 (6th Cir. 1989), *cert. denied*, 495 U.S. 905 (1990); *Stoetzner v. U.S. Steel Corp.*, 897 F.2d 115, 119 n. 5 (3d Cir. 1990); *Johnson v. Enron Corp.*, 906 F.2d 1234, 1238 (8th Cir. 1990); *Jett v. Blue Cross/Blue Shield of Alabama, Inc.*, 890 F.2d 1137, 1139 (11th Cir. 1989).

1552, 1558 (5th Cir. 1991), *cert. denied*, 502 U.S. 973 (1991), which held that an administrator's factual determinations are always governed by a deferential review standard, irrespective of whether the plan grants discretionary authority. In the present case, the Fifth Circuit did not even cite *Pierre* much less rely on it. Instead, it agreed with the District Court's conclusion that the Administration Agreement "specifically gave [Jacobs] discretionary authority to make determinations regarding eligibility for benefits and discretionary authority to review denied claims." (Appendix B to Petition, pp. 44-5).

The third question presented – whether the deferential review standard requires more than a scintilla of evidence in order to uphold a fiduciary's decision – is not presented by this case and does not raise an important question to be decided by this Court. The Fifth Circuit correctly found that "we are . . . faced with the undeniable fact that the record reflects *substantial* evidence supporting Jacobs' decision." (Emphasis added). (Appendix D to Petition, p. 50). Furthermore, the benefit denial in this case – which has been upheld by two courts – turned on Ms. Gregory's unique medical history and physical capabilities, thus making review by this Court all the more inappropriate.

III

ARGUMENT

A. Petitioner Conceded The First Question Before The Fifth Circuit And, In Any Event, The Issue Is Not A Source Of Conflict Among The Circuits

The first question presented is what ERISA plan language is necessary to vest a claims review fiduciary with

discretionary authority to determine benefit eligibility. As reflected above, Ms. Gregory's counsel began his argument to the Fifth Circuit by conceding that the "arbitrary and capricious" review standard applied in this case, and he then argued that the Benefit Review Committee abused its discretion in not upholding her appeal. Having conceded the standard of review before the Fifth Circuit, Ms. Gregory now should not be permitted to claim error to the Supreme Court.[7]

Even apart from having conceded the first question, Ms. Gregory errs in arguing there is a Circuit conflict as to what plan language is necessary to vest the fiduciary with discretionary authority to determine benefit eligibility. Neither does the first question present an issue of general or continued importance that should be resolved by this Court. Instead, the inquiry required by *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989), involves a case-by-case review of the particular and often unique language in each plan to determine whether it confers discretionary authority to determine benefit eligibility or to construe the plan terms. Moreover, this issue

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[7] Ordinarily, this Court does not decide questions not "pressed or passed upon" below. *United States v. Williams*, 504 U.S. 36, 40-3 (1992); *California v. Taylor*, 353 U.S. 553, 557 n. 2 (1957). Although this Court has made exceptions to this rule, it recently found that an important factor was that the party "did not concede in the current case the correctness of [the challenged] precedent." *Williams* at 45. Having conceded the standard of review in oral argument, petitioner did not vigorously press her case and invited the decision below. The resulting opinion was a "routine restatement and application of settled law" by the Fifth Circuit, which is insufficient to satisfy the "pressed or passed upon" rule. *Illinois v. Gates*, 462 U.S. 213, 222-223 (1983).

is of increasingly less interest as more and more plans are amended to mirror the exact language used in *Firestone.* In the present case, it is manifest that the Fifth Circuit's decision follows *Firestone.*

In *Firestone,* this Court considered the standard of judicial review of a plan administrator's denial of benefits. It held that in reviewing the fiduciary's decision, the district court is to apply a *de novo* standard unless the fiduciary has "discretionary authority to determine eligibility for benefits or to construe the terms of the plan." If discretionary authority has been granted, a "deferential standard of review" is appropriate. *Id.* The Court did not require that the plan expressly grant discretionary authority in order for the fiduciary's decision to be judged by the "arbitrary and capricious" standard of review. *Id. See Bali v. Blue Cross & Blue Shield Ass'n,* 873 F.2d 1043, 1047 (7th Cir. 1989).

Ms. Gregory correctly states that the issue in the present case is whether the Plan's language conferred upon Jacobs " 'sufficient discretionary authority' to determine *claims eligibility* for benefits." (Petition, p. 14). This case does *not* involve the interpretation of an ambiguous provision in an employee benefit plan.

Contrary to Ms. Gregory's representation (Petition, pp. 14-7), the Circuits are not in conflict as to what plan language is necessary for the fiduciary's decision on *benefit eligibility* to be reviewed under an "arbitrary and capricious" standard. The situation is exactly the opposite; the courts agree that no "magic words" are necessary. *Duhon v. Texaco, Inc.,* 15 F.3d 1302, 1305-06 (5th Cir. 1994); *Block v. Pitney Bowes, Inc.,* 952 F.2d 1450, 1453-4 (D.C. Cir. 1992); *de Nobel v. Vitro Corp.,* 885 F.2d 1180, 1187 (4th Cir. 1989);

Bogue v. Ampex Corp., 976 F.2d 1319 (9th Cir. 1992), *cert. denied*, 113 S.Ct. 1847 (1993). In *Block*, Judge (now Justice) Ginsburg wrote: "The Court in *Firestone* surely did not suggest that 'discretionary authority' hinges on incantation of the word 'discretion' or any other 'magic word.' " 952 F.2d at 1453.

As demonstrated below, the Circuits, without any split, have consistently found that the language of employee benefit plans may contain two primary sources of discretionary authority for determining benefit eligibility, each of which is sufficient by itself to invoke a deferential review. The first source is plan language stating that the fiduciary shall make a *"determination"* of benefit entitlement based on plan criteria. The second source is plan language stating that the fiduciary's decision on benefit entitlement shall be *"final," "binding,"* or *"conclusive." Both* of these sources of discretionary authority are present here.

Indeed, the Tenth Circuit, in addressing the same Administration Agreement between Jacobs and ARCO as this case, but not the same plan, applied the "arbitrary and capricious" review standard, observing that "[t]he district court found, and the parties do not dispute, that Jacobs had discretionary authority to determine eligibility for benefits." *Sandoval v. Aetna Life and Casualty Ins. Co.*, 967 F.2d 377, 379-80 (10th Cir. 1992).

As indicated, the Plan states that benefits are payable, following an initial two years of benefit payments, if the participant, "because of a continuing *medically determinable* physical or mental impairment . . . " is "unable to engage in any gainful employment or occupation for

which [the participant is] reasonably qualified by education, training or experience. . . . " (Emphasis added). The Administration Agreement gives Jacobs the authority to *"determine"* whether the claimant has *"qualified for Benefits by reason of the health and capacity to work criteria defined in the Plan."*[8] It further specifies that Jacobs has the "authority to make *determinations* regarding Benefit entitlement under the Plan," including the review of denied claims as "named fiduciary, as defined in ERISA" and that Jacobs' "decision on any claim shall be *final*" (Emphasis added).

It is well-settled that sufficient discretionary authority to determine benefit eligibility exists where, as here, the plan language gives the fiduciary the power to make *"determination"* of whether benefits are payable based on criteria set forth in the plan. *Bogue v. Ampex Corp.*, 976 F.2d 1319 (9th Cir. 1992), *cert. denied*, 113 S.Ct. 1847 (1993) ("arbitrary and capricious" review standard applies where plan administrator is to make a "determination" of eligibility based on plan criteria); *Eley v. Boeing Co.*, 945 F.2d 276, 278 (9th Cir. 1991) (plan administrator "shall determine the eligibility of a person for benefits under the plan" and "retains final authority and responsibility for the Plan and its operation"); *Boyd v. Trustees of United Mine Workers Health & Retirement Funds*, 873 F.2d 57, 59 (4th Cir. 1989) (trustee given power of "full and final determination as to all issues concerning eligibility for benefits" and authorized to promulgate rules).

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[8] Fiduciary powers may be delegated by the plan administrator to another fiduciary which then succeeds to those powers, including discretionary authority to determine eligibility for benefits. *Madden v. ITT Long Term Disability Plan for Salaried Employees*, 914 F.2d 1279, 1284-5 (9th Cir. 1990), *cert denied*, 498 U.S. 1087 (1991).

In *Bogue, supra,* Judge Wisdom, sitting by designation, stated that the "full extent of the [severance pay plan's fiduciary's] discretion [lay] in the phrase *'[t]he determination . . . will be made . . .* upon consideration of whether the new position . . . has responsibilities *similar to those* of [the employee's] *current position.*" (Emphasis in original). 976 F.2d at 1324. Finding this to be a sufficient grant of discretionary authority, he stressed the significance of the word "determination" by stating:

> . . . the language in the Allied-Signal program . . . grants Allied-Signal the authority to evaluate and determine facts, including whether an employee's prior and prospective positions are 'similar'. This evaluation necessarily invokes a *judgmental function* in analyzing the positions. Under *Firestone,* this is sufficient evidence of a grant of discretionary authority. . . . (Emphasis added). *Id.* at 1325.

Similarly, it is well-settled that sufficient discretionary authority exists where, as here, the plan language makes the fiduciary's decision *"final," "binding"* or *"conclusive." Duhon v. Texaco, Inc.,* 15 F.3d 1302, 1305-06 (5th Cir. 1994) ("arbitrary and capricious" review standard applies where the plan provides that "the decisions of the Plan Administrator shall be final and conclusive with respect to every question which may arise relating to either the interpretation or administration of this Plan"); *Stoetzner v. U.S. Steel Corp.,* 897 F.2d 115, 119 n. 5 (3d Cir. 1990) (plan provides administrator's decision "shall be final and conclusive as to all questions of interpretation and application"); *Johnson v. Enron Corp.,* 906 F.2d 1234, 1238 (8th Cir. 1990); *Richards v. United Mine Workers of America Health & Retirement Plan,* 895 F.2d 133, 135 (4th Cir. 1990) (plan provides "trustee shall have full and final

determination as to all issues concerning eligibility for benefits" and can promulgate "binding" rules and regulations); *Davis v. Kentucky Fin. Co. Retirement Plan*, 887 F.2d 689, 694 (6th Cir. 1989), *cert. denied*, 495 U.S. 905 (1990); *Jett v. Blue Cross/Blue Shield of Alabama, Inc.*, 890 F.2d 1137, 1139 (11th Cir. 1989) ("reasonable determinations" in plan administration "shall be final and conclusive").

As correctly summarized in M. Beaver, "The Standard of Review in ERISA Benefits Denial Cases After *Firestone Tire and Rubber Co. v. Bruch:* Revolution or Deja Vu?," *Tort & Insurance Law Journal*, Vol. XXVI, No. 1, pp. 1, 10 (1990):

> The post-*Bruch* cases reveal that *discretion may be implied from a wide range of plan provisions* and circumstances. A number of courts have found implied discretionary authority based upon a plan provision simply giving the plan administrator the power to make benefits eligibility *determinations* and to interpret plan terms. One court has suggested, in fact, that *'any* evidence of a grant of discretionary authority' should result in deferential review. *A common thread in many of these cases is that the plan document provides for the administrator's decision to be 'final', 'binding', or 'conclusive.'* (Footnotes omitted) (Emphasis added.)

In a similar vein, *Employee Benefits Law* (Bureau of National Affairs/American Bar Association, Section of Labor and Employment Law), 1994 Cumulative Supplement at pp. 155-7, states:

> The circuits have consistently held that general power-granting clauses supplemented with such phrases as . . . 'power to determine eligibility' constitute grants of discretionary authority. Plan

> language stating the fiduciary's decision is 'final,' 'conclusive,' 'binding' or 'exclusive' has likewise been held to grant the fiduciary the discretionary authority contemplated in *Firestone.* (Footnotes omitted).[9]

As shown above, this case involves a question of benefit eligibility determination, not the interpretation of an ambiguous plan provision.

In cases involving the interpretation of ambiguous plan provisions, some of the Circuits have taken a more restrictive view as to what plan language will trigger the "arbitrary and capricious" review standard. The decisions cited by Ms. Gregory and discussed below do not, however, support her argument that this case – involving an issue of determining benefit eligibility – raises an issue which has split the Circuits. (Petition, pp. 13-20).

In *Baxter v. Lynn,* 886 F.2d 182, 188 (8th Cir. 1989), for example, the court held that plan language requiring the trustees to make a final determination of eligibility for

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[9] Agreement among the Circuits on these issues is also noted in D. Bacon, S. Prater, D. Tucker, *Employee Benefits Guide* (Matthew Bender & Co.) (1994), § 8.03[4] n. 30. *See also* Defense Research Institute, *ERISA Litigation Primer – 1994,* at pp. 15-6:

> The circuits have been fairly consistent in holding general power-granting clauses with such phrases as . . . *'power to determine eligibility'* do grant the discretionary authority referenced by *Firestone.* . . . In addition, many plans specify that the fiduciary's decision is 'final,' 'conclusive,' 'binding' or 'exclusive.' For the most part, plans that contain this type of language have been held to grant the fiduciary discretionary authority entitling its benefits determinations to deference.

benefits does not necessarily confer discretionary authority to render decisions with regard to ambiguous provisions of the plan. Unlike the present case, *Baxter* involved the interpretation of an ambiguous provision in a plan.

In *Baker v. Big Star Div. of the Grand Union Co.*, 893 F.2d 288, 291 (11th Cir. 1989), the court concluded that an insurance company, which merely performed initial claims handling and was not the ERISA claim review fiduciary, could not have the discretionary authority to determine benefit eligibility. In contrast to *Baker*, ARCO did not merely "rent" Jacobs' claim department. To the contrary, Jacobs performs initial claims handling and its Benefit Review Committee serves as the ERISA claims review fiduciary, hearing the appeal of the denied claims. The District Court correctly concluded that the Administration Agreement "specifically gave [Jacobs] discretionary authority to make determinations regarding eligibility for benefits and discretionary authority to review denied claims." (Appendix B to Petition, pp. 44-5).

In *Luby v. Teamsters Health, Welfare and Pension Trust Funds*, 944 F.2d 1176, 1180 (3d Cir. 1991), the court held that plan terms which simply authorized the trustees to amend the Declaration of Trust, and thus the system of trust administration, did not confer discretionary authority to make benefit determinations. Here, in contrast, the Plan specifically gives the fiduciary the discretionary authority to make determinations of benefit eligibility and specifies that the fiduciary's decision in the ERISA appeal procedure will be "final."

In *Ziaee v. Vest*, 916 F.2d 1204, 1206-07 (7th Cir. 1990), *cert. denied*, 499 U.S. 959 (1991), the court held that plan provisions giving the trustee discretion over investment

strategies did not create a power to construe disputed or doubtful terms. *Ziaee* – unlike the present case – involved the interpretation of an ambiguous plan provision.

In *Taylor v. Continental Group Change in Control Severance Pay Plan*, 933 F.2d 1227, 1232 (3d Cir. 1991), the court held that a plan administrator did not have discretionary authority to interpret an ambiguous plan provision; the plan provisions were not quoted but the court stated that no discretionary authority was granted.

In *Brewer v. Lincoln National Life Ins. Co.*, 921 F.2d 150, 153-54 (8th Cir. 1990), *cert. denied*, 501 U.S. 1238 (1991), unlike the present case, the court interpreted an ambiguous plan provision. The opinion does not discuss any plan provisions which might arguably have granted discretion to the plan administrator to interpret the plan.

In short, not only has Ms. Gregory conceded the standard of review before the Court of Appeals, but the present case does not even present the issue which she contends has created a Circuit "conflict" – what plan language is sufficient to trigger discretionary authority to interpret ambiguous plan provisions. As reflected above, the Circuits are in agreement with respect to the issue involved here – what plan language is sufficient to grant discretionary authority to determine *benefit eligibility.* Although no "magic language" is necessary, the appellate courts have held that two primary sources of discretionary authority are found in plan language stating that a fiduciary shall make a *"determination"* of benefit entitlement based on plan criteria, or that its decision on benefit entitlement shall be *"final," "binding"* or *"conclusive." Block, supra; de Nobel, supra; Bogue, supra; Duhon, supra;*

Richards, supra; Davis, supra. This conclusion that the Circuits are in agreement is fully confirmed by the law journal and ERISA treatise passages cited above.

The first question thus presents no Circuit conflict or significant federal question to be resolved by this Court. Far from being a maverick case, the Fifth Circuit's decision follows *Firestone* and the well-developed lines of authority holding that discretionary authority may arise from plan language stating either that the fiduciary may make a "determination" of benefit entitlement based on plan criteria, or that its decision shall be "final," "binding" or "conclusive."

B. The Second Question Presented Involves An Issue That Was Conceded By Petitioner And, Moreover, Is Not Even Raised By The Fifth Circuit Decision

The second question presented in the Petition is whether a *de novo* review should apply where the plan grants no discretionary authority and an administrator makes factual determinations of benefit eligibility. The Petition specifically seeks to challenge the Fifth Circuit's holding in *Pierre v. Connecticut General Life Ins. Co.*, 932 F.2d 1552, 1558 (5th Cir. 1991), *cert. denied*, 502 U.S. 973 (1991), that an administrator's factual determinations are always governed by an "arbitrary and capricious" review standard, regardless of whether the plan grants discretionary authority. (Petition, pp. 20-4).

This case, however, does not present a logical or acceptable vehicle for reviewing the principle set forth in *Pierre* for three reasons.

First, as shown above, Ms. Gregory conceded to the Fifth Circuit that the "arbitrary and capricious" review standard governs this case, and now she should not be allowed to complain about error to this Court.

Second, the question presented is not even raised by this case. The Fifth Circuit did not cite *Pierre* much less rely on it in reaching its decision.[10] As shown above, the District Court concluded that the Administration Agreement "specifically gave [Jacobs] discretionary authority to make determinations regarding eligibility for benefits and discretionary authority to review denied claims." (Appendix B to Petition, pp. 44-5). The appellate court relied on this grant of discretionary authority in holding that Jacobs' determination should be reviewed for abuse of discretion, stating:

> *See Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 . . . (1989) (holding review is limited to abuse of discretion when plan confers discretion on plan administrator in determining benefits eligibility). (Appendix D to Petition, p. 52).

Third, as indicated above, the Fifth Circuit's decision follows *Firestone* and the well-developed lines of authority holding that discretionary authority is contained in plan language empowering the fiduciary to make a "determination" of benefit eligibility based on plan criteria, or specifying that its decision shall be "final," "binding" or "conclusive." Moreover, the question of what plan

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[10] Accordingly, the question presented was not "pressed or passed upon below." Except in unusual circumstances, this Court will not review a question that was neither pressed nor passed on below. *United States v. Williams*, 504 U.S. 36, 40-3 (1992); see discussion *supra*, n. 7.

language is necessary to invoke a deferential review is of increasingly diminishing interest as more and more plans are amended to conform to the precise wording of *Firestone*.

C. The Third Question Presented Is Not Raised By This Case And Does Not Present A Significant Question

The third question presented is whether more than a scintilla of evidence should be required in order to uphold an ERISA claims review fiduciary's decision to deny benefits under an abuse of discretion standard. This is a question which Ms. Gregory has made up out of whole cloth.

This issue plainly is not presented by the present case because the Fifth Circuit found that "we are . . . faced with the undeniable fact that the record reflects *substantial* evidence supporting Jacobs' decision." (Emphasis added). (Appendix D to Petition, p. 53). The appellate court did not affirm based on a mere scintilla of evidence. In addition, Ms. Gregory waived this issue by not raising it before the Fifth Circuit. Neither does the question present an important issue to be reviewed by this Court.

The District Court found that "little, if any, objective medical evidence" supported the claim, and that there was sufficient evidence before the Benefit Review Committee on which it could base its decision to deny the claim. (Appendix B to Petition, p. 46). In their brief to the Fifth Circuit, Jacobs and ARCO argued that fiduciary's decision should be affirmed under the "arbitrary and capricious" review standard because it was based on *substantial* evidence, and that substantial evidence is

more than a scintilla but may be less than preponderance. *Sandoval v. Aetna Life and Casualty Ins. Co.*, 967 F.2d 377, 382 (10th Cir. 1992). *See also Hancock v. Montgomery Ward Long Term Disability Trust*, 787 F.2d 1302, 1308 (9th Cir. 1986); *Roe v. General American Life Ins. Co.*, 712 F.2d 450, 452 (10th Cir. 1983); *LeFebre v. Westinghouse Electric Corp.*, 747 F.2d 197, 208 (4th Cir. 1984). (Brief of Appellees, p. 30). No one contended, and the courts did not conclude, that the evidentiary standard was a mere "scintilla."

As indicated above, the Fifth Circuit concluded that the Benefit Review Committee's decision should be affirmed because it was based on *substantial* evidence. (Appendix D to Petition, p. 53). Indeed, the fiduciary's decision was premised on a well-supported factual showing that in 1988 Ms. Gregory – five years after the injury – was no longer totally disabled as defined in the Plan. This was not even a close case. Ms. Gregory's youth, education, training and experience, coupled with the objective medical evidence and reports of her physical capabilities, convincingly demonstrated in 1988 she was capable, at the very least, of sedentary work. As ARCO and Jacobs argued to the Fifth Circuit, the overwhelming weight of evidence regarding her medical condition and physical capabilities established that the District Court's decision could be upheld even under a *de novo* review standard. (Brief of Appellees, p. 34).

Because the findings of fact made by the District Court received the concurrence of the Fifth Circuit, this case – with its unique facts involving Ms. Gregory's medical history and physical capabilities – is especially inappropriate for Supreme Court review of the evidentiary

standard to be applied ("substantial evidence," not "scintilla"), much less the *sufficiency* of the evidence. Application of the "two court rule" bars review by this Court "in the absence of a very obvious and exceptional showing of error." *Graver Tank & Mfg. Co. v. Linde Air Products Co.*, 336 U.S. 271, 275 (1949); *Berenyi v. District Director, Immigration and Naturalization Service*, 385 U.S. 630, 635 (1967); *Branti v. Finkel*, 445 U.S. 507, 512 n. 6 (1980). Ms. Gregory cannot show any such error.

One reason why the Petition strains to include a third question presented is that Ms. Gregory seeks to have this Court adopt in ERISA the social security "treating physician" rule, under which the opinion of the treating physician is followed unless it is contradicted by substantial evidence. *Floyd v. Bowen*, 833 F.2d 529, 531 (5th Cir. 1987) (social security case). (Petition, pp. 26-7). The "treating physician" rule has been rejected under ERISA. *See Salley v. E.I. Dupont deNemours & Co.*, 966 F.2d 1011, 1016 (5th Cir. 1992). This issue is not even properly raised here because, as found by the courts below, substantial, objective evidence in the record contradicted the opinions of Drs. Khalil and Chaput that Ms. Gregory could not even engage in sedentary work.[11]

Moreover, the "treating physician" rule developed in social security cases cuts across the grain of ERISA. ERISA's written plan instrument rule, which is one of "ERISA's core functional requirements," *Curtiss-Wright Corp. v. Schoonejongen*, ___ U.S. ___, ___, 115 S.Ct. 1223,

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[11] In addition, as the District Court found, at the time the Benefit Review Committee made its decision, Social Security had denied benefits. (Appendix B to Petition, p. 36).

1230 (1995), requires that employee benefit plans be established in writing, and that those written terms – which include the ERISA appeal procedures – must be followed. 29 U.S.C. §§ 1102(a)(1), 1104(a)(1)(D), 1133; *Nachwalter v. Christie*, 805 F.2d 956, 960 (11th Cir. 1986); *Greany v. Western Farm Bureau Life Ins. Co.*, 973 F.2d 812, 822 (9th Cir. 1992). Rather than stating that a plan is bound by the treating physician's opinion, ERISA requires that every plan have a *"named fiduciary"* who hears the appeal of denied claims, § 1133, subject only to judicial review. It is well-settled that the ERISA plan may accept the opinion of an independent medical expert over the opinion of the treating physician. *Sandoval v. Aetna Life and Casualty Ins. Co.*, 967 F.2d 377, 378, 382 (10th Cir. 1992); *Hancock v. Montgomery Ward Long-Term Disability Trust*, 787 F.2d 1302, 1307 (9th Cir. 1986). Here, the Plan's written instruments grant discretionary authority to determine benefit entitlement and specify that the Benefit Review Committee's "decision" on any claim is "final."

IV CONCLUSION

Respondents respectfully request that the Petition for Writ of Certiorari be denied. The Petition presents, as its first two questions, issues which petitioner conceded at oral argument before the Fifth Circuit. In addition, there is no split among the Circuits but rather uniformity as to the first question – the plan language necessary so that a fiduciary has discretionary authority to determine benefit entitlement. The second question, involving the *Pierre* case, and the third question, involving a scintilla of evidence, are not even presented by this case, and petitioner waived the third question. As demonstrated, the two decisions below are not only in conformity with *Firestone*,

but were correctly decided based on the Plan's broad power-granting language and the petitioner's unique medical history and physical capabilities, all of which make this case especially inappropriate for review.

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